03/22/2011 09:16 8655945739 HEALTH CARE FACILITY PAGE 04/30
PRINTED: 03/21/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 4/30/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445126	A. BUILDING _____ B. WING _____	03/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, SEQUATCHIE	380 DELL TRAIL, PO BOX 878 DUNLAP, TN 37327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On March 14-16, 2011 the annual Recertification Survey and investigation of complaints #'s 26436 and 27013, and 27138 was completed. No deficiencies were cited for complaints 26436 and 27138.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	The Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. F 157 D 1. Resident #20 is no longer in facility. 2. All residents receiving a new medication will have medical record reviewed to assure proper physician notification and correct documentation of any order obtained.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 3/25/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the physician to obtain an order for treatment fir one resident (#20) of twenty-three residents reviewed. The findings included: Resident #20 was admitted to the facility on September 14, 2010, with diagnoses including Aftercare for Right Hip Replacement, Osteopenia, Chronic Obstructive Pulmonary Disease, Hypertension and Chronic Kidney Disease Stage II-IV. Medical record review of a nurse's note dated October 5, 2010, at 6:00 p.m., revealed, "...In bed. Dinner served + (and)resident vomited as soon as (resident) saw food. Yellow emesis. Breathing Tx. (treatment) held. Denies any c/o (complaint of) pain. Skin W+D (warm and dry) Resp. (respirations) unlabored. Will cont. (continue) to monitor ..." and at 7:00 p.m., " ...Temp. (temperature) 101.0 degrees A (axillary)-ii (two) Tylenol po (by mouth) given ..." Continued medical record review of nurse's notes revealed on October 6, 2010, at 8:00 a.m., " ... T (temperature) 97.4 degrees ..." Medical record review of the Physician's Recapitulation Orders dated October 1-31, 2010, and of Physician's Telephone Orders for the month of October, 2010, revealed no order for the Tylenol that was given. Interview with the Director of Nursing (DON) and	F 157	3. All nurses will be inserviced regarding notification of physician in all areas covered in F 157 and the proper documentation to support notification. 4. Any new medication given to a resident will be identified on the "End of Shift Communication Sheet." The Quality Assurance Nurse will review the "End of Shift Communication Sheets" on an ongoing basis and assure proper documentation procedures were followed. April 22, 2011	

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F 157	Continued From page 2 the Assistant Director of Nursing (ADON), in the DON's office, on March 16, 2011, at 9:15 a.m., confirmed the facility failed to notify the physician to obtain an order for the Tylenol. Complaint # 27013	F 157	F 279 D 1. The care plan of Resident #7 has been revised to reflect current oxygen order and usage.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to address the use of oxygen on the Interim and Comprehensive Care Plan for one resident (#7), of twenty-three resident's reviewed.	F 279	2. The care plans of all residents receiving oxygen will be reviewed to assure appropriate plan of care is followed. 3. An inservice will be held with all nurses regarding the development of comprehensive care plans that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment and describes services provided. 4. The nurses responsible for ongoing care plans will review all residents receiving oxygen monthly and report results to the Quality Assurance Committee until there is 100% compliance for three consecutive months. April 22, 2011	

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F 279	Continued From page 3 The findings included: Resident #7 was admitted to the facility on December 3, 2010, with diagnoses including Pneumonia, Gastroesophogeal Reflux Disease, Diabetes Mellitus, Osteoarthritis, Hypertension and Muscle Weakness. Medical record review of the Minimum Data Set dated March 3, 2011, revealed the resident had mild cognitive impairment, required the use of oxygen and became short of breath when lying flat. Medical record review of the admitting orders and January, February and March 2011, Physician Recapitulation Orders revealed, "...O2 (oxygen) @ (at) 2L (Liter) per NC (nasal cannula)..." Medical record review of the Interim and Comprehensive Care Plan dated December 3, 2010, revealed the resident's use of oxygen was not addressed. Observation of the resident on March 15, 2011, at 7:45 a.m., revealed the resident asleep in bed, the head of the bed elevated, the resident receiving oxygen at two liters by nasal cannula. Interview with the Director of Nursing (DON) in the DON office on March 15, 2011, at 9:00 a.m., confirmed the facility failed to address the resident's oxygen needs on the Interim and Comprehensive Care Plans.	F 279	F 281 D 1. Resident #3's laboratory results have been obtained, placed on chart and physician notified. 2. All laboratory specimens currently being processed have been reviewed and no other residents are affected 3. Inservice will be held with all nurses to assure the Laboratory Tracking Procedure is being followed. 4. The Quality Assurance Nurse will monitor the Laboratory Tracking Form to assure the laboratory results are received in a timely manner. Issues of not receiving the laboratory results in a timely manner will be reported to the Director of Nursing for resolution with the Laboratory Director.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview the facility failed to ensure lab results were obtained in a timely manner for one (#3), and failed to follow professional standards in transcribing physician orders to ensure accuracy for one (#22) of twenty-three residents reviewed. The findings included: Resident #3 was admitted to the facility on March 1, 2010, with diagnoses including Alzheimer's Disease, Hypertension, Chronic Obstructive Pulmonary Disease, and Depression. Review of the Physician's Progress Note dated October 28, 2010, revealed the resident had been admitted to the hospital psychiatric unit with diagnoses of dementia and paranoid psychosis. Review of the Minimum Data Set (MDS) assessment dated February 2, 2011, revealed the resident had severe cognitive impairment, and was dependent on staff to assist with personal hygiene maintenance. Medical record review of the resident's recapitulation orders dated March 1 through March 31, 2011, revealed the resident received Depakote Sprinkles (divalproex sodium, a derivative of valproic acid) 125 mg (milligrams)/capsule, 4 capsules (500 mg), twice a day. Review of the Geriatric Dosage Handbook for the indications for use of divalproex sodium, revealed "...a number of studies which demonstrate...benefit in the treatment of agitation and dementia and other psychiatric disorders..."	F 281	1. Resident #22 is no longer in facility. 2. All orders will be reviewed to assure the resident's name, the name of the medication, the dosage of the medication, the route of administration and the time of administration is included. 3. An inservice will be held with the nurses on what must be included in a physician's order. 4. The Quality Assurance Nurse will review all orders on an ongoing basis to assure proper documentation. Correction will be made as needed.	April 22, 2011

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F 281	Continued From page 5 Review of the Physician's Order dated March 4, 2011, revealed a lab order for valproic acid level. Medical record review conducted on March 15, 2011, revealed no documentation the lab results had been received by the facility. Review of the facility policy, Laboratory Tracking Procedure, revealed, "...The nurse obtaining the specimen will initiate the Laboratory Tracking Log...Each nurse should check tracking form daily to assure reports are returned in a timely manner...In the event the report is not returned in a timely manner, the nurse should contact the lab and request results be faxed..." Interview with the Assistant Director of Nursing in the Social Services office on March 15, 2011, at 12:45 p.m., confirmed the lab results had not been obtained in a timely manner. Resident #22 was admitted to the facility on March 12, 2010, with diagnoses including Alzheimer's Disease, Congestive Heart Failure, Hypertension, and history of Pulmonary Embolism. Review of the Physician's Orders and Coumadin Tracking Log from March 2010 through January 9, 2011, revealed the resident received anticoagulant therapy on a routine basis with frequent dosage adjustments to maintain therapeutic drug levels. Review of the physician's order dated August 17, 2010, revealed, "1) 10 mg (milligrams) i (one) po (by mouth) x 2 days, then 2) 5 mg i po q (every) daily, 3) PT (protime) with INR (international normalized ratio) check in 1 week."	F 281		

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F 281	Continued From page 6 Review of the physician's order dated August 30, 2010, revealed, "6) Coumadin 5 mg. Alternate with 6 mg, 7) Coumadin 6 mg - Alternate with 5 mg." Interview with the Assistant Director of Nursing in the Director of Nursing's office on March 16, 2011, at 8:45 a.m., confirmed complete and accurate physician's orders should include the resident's name, the name of the medication, the dosage of the medication, the route of administration, and the time of administration. Continued interview confirmed the orders dated August 17 and August 30, 2010, were incomplete and did not follow professional standards.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide hygiene for a contracted hand for one (#1) of twenty three residents reviewed. The findings included: Resident #1 was admitted to the facility on August 10, 2007, with diagnoses including Advanced	F 312	F 312 D 1. Resident #1 has hand clean with no odor and adaptive roll in place on 3/16/11. As of 3/16/11, Range of Motion to contracted left hand is performed each shift during cleaning and through drying of affected hand. 2. All residents with a contracture will be assessed for hygiene, applicable adaptive equipment and need for daily range of motion of affected area of the body.	

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F 312	Continued From page 7 Alzheimer's Dementia, Arthritis, and Osteoporosis. Medical record review of the Minimum Data Set dated February 18, 2011, revealed the resident had impaired short and long term memory and required total assistance with all activities of daily living. Observation on March 14, 2011 at 1:15 p.m., and on March 15, 2011, at 7:15 a.m., in resident #1's room revealed the resident in the bed, the right hand was contracted and in a fist. Observation on March 15, 2011, at 9:55 a.m., revealed Certified Nurse Assistant (CNA) #1 and CNA #2 provided a partial bed bath for the resident without cleansing the right hand. Observation and interview on March 15, 2011, at 10:10 a.m., in the resident's room with Licensed Practical Nurse (LPN) #4 and CNA #1, revealed the resident's right hand was contracted and in a fist; the palm of the right hand was moist and had a very foul odor. Interview at that time with LPN #4 and CNA #1 confirmed hygiene was not provided for the right hand, the palm of the right had was moist and had a very foul odor.	F 312	3. An inservice will be held with the nursing staff stressing the importance of range of motion and hygiene for contracted areas of the body as well as the use of different types of adaptive equipment. 4. All staff nurses will monitor all residents with contracture every shift to assure proper hygiene and adaptive equipment is in place.	April 22, 2011
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care;	F 328		

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F 328	Continued From page 8 Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure oxygen was provided as ordered for one resident (#7) of twenty-three residents reviewed. The findings included: Resident #7 was admitted to the facility on December 3, 2010, with diagnoses including Pneumonia, Gastroesophogeal Reflux Disease, Diabetes Mellitus, Osteoarthritis, Hypertension and Muscle Weakness. Medical record review of the Minimum Data Set dated March 3, 2011, revealed the resident had mild cognitive impairment, required the use of oxygen and became short of breath when lying flat. Medical record review of the admitting orders, dated December 3, 2010, and Physician Recapitulation Orders dated January, February and March 2011, revealed, "...O2 (oxygen) @ (at) 2L (Liter) per NC (nasal cannula)..." Observation in the resident's room on March 14, 2011, at 1:30 p.m., and 3:10 p.m., revealed the resident in bed and no oxygen equipment in the room. Interview with LPN #1, on March 14, 2011, at 3:30 p.m., in the resident's room, confirmed the facility failed to provide the resident's oxygen.	F 328	F 328 D 1. Resident #7 is currently receiving oxygen as outlined in physician's order. 2. All residents with an order for oxygen will be evaluated to assure oxygen is being given per physician's orders. 3. An inservice will be held with the nurses stressing the importance of following the physician's orders regarding oxygen use and ongoing assessment of oxygen needs. 4. All staff nurses will perform ongoing assessment of all residents receiving oxygen to assure current order is being followed and no changes are needed. The third shift nurse will perform weekly audits of all residents receiving oxygen to assure physician's order is being followed. The results of these audits will be given to the Director of Nursing.	April 22, 2011

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F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain an accurate clinical record for one resident (#7) of twenty-three residents reviewed. The findings included: Resident #7 was admitted to the facility on December 3, 2010, with diagnoses including Pneumonia, Gastroesophageal Reflux Disease, Diabetes Mellitus, Osteoarthritis, Hypertension and Muscle Weakness. Medical record review of the Minimum Data Set dated March 3, 2011, revealed the resident to have mild cognitive impairment, required the use of oxygen and became short of breath when lying flat. Medical record review of the admitting orders	F 514	F 514 1. Resident #7 is receiving oxygen per physician order is properly documented. 2. All residents receiving oxygen will be assess to assure there is proper documentation in the medical record. All residents transferred from one station to another will have all medical records transferred as well. 3. Inservice will be held with all nurses to assure proper documentation guidelines are observed and all medical records transferred with the resident. 4. The third shift nurse will perform weekly audits of oxygen documentation on the Nursing Flow Sheet of all residents receiving oxygen. The results of these audits will be given to the Director of Nursing.	April 22, 2011

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F 514	Continued From page 10 dated December 3, 2010, and January, February and March 2011, Physician Recapitulation Orders revealed, " ...O2 (oxygen) @ (at) 2L (Liter) per NC (nasal cannula) ..." Medical record review of the Medication Administration Record (MAR), Page 1 of 1, dated March 1-31, 2011, revealed " ...O2 at 2L PER NC ..." had been signed as being checked by nurses assigned to Nursing Station One every shift from March 11-14, 2011. Observation in the resident's room on March 14, 2011, at 1:30 p.m., and 3:10 p.m., revealed the resident in bed. No oxygen equipment was in the room. Interview with Licensed Practical Nurse (LPN) #1, on March 14, 2011, at 3:35 p.m., at Nursing Station Two confirmed, "... (Resident) moved from Station One to Station Two on Friday (March 11, 2011)..." Further interview confirmed the resident's MAR, Page 1 of 1, dated March 1-31, 2011, remained at Nursing Station One after the resident was moved, until the Surveyor brought it to the attention of LPN #1. Continued interview confirmed Station One nursing staff continued to document the resident was receiving oxygen after the resident was moved to Nursing Station Two and was not receiving oxygen. Interview with the Director of Nursing (DON) on March 15, 2011 at 9:00 a.m., in the DON office, confirmed the facility failed to accurately document the resident's oxygen usage.	F 514		